SOUTH DAKOTA

DIABETES

PROGRAM

Presenter

Kayla Magee, RN

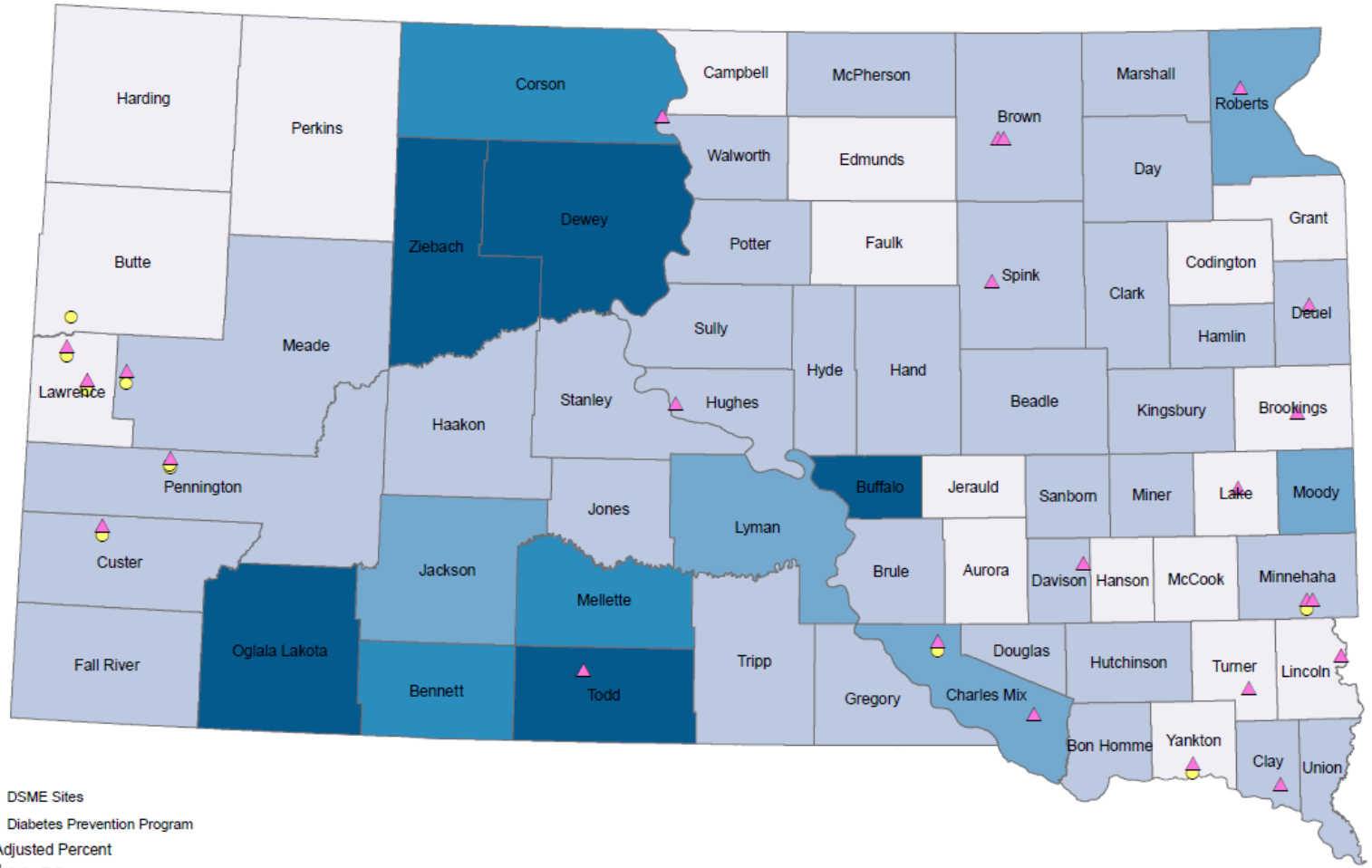
Diabetes Program Coordinator

Diabetes Prevention & Control Program

South Dakota Department of Health

Kayla.magee@state.sd.us

Diabetes Prevalence by County, 2013



DSME Sites

Diabetes Prevention Program

Age-Adjusted Percent

- 6.2 - 7.3
- 7.4 - 8.6
- 8.7 - 10.0
- 10.1 - 13.6
- 13.7 - 19.4

Diabetes prevalence data was accessed June 30, 2016 via the CDC Diabetes Interactive Atlas County Data Indicators: http://www.cdc.gov/diabetes/data/countydata/countydataindicators.html. The list of Diabetes Prevention Program Sites was obtained 6/27/2016 via the South Dakota Department of Health. Prevalence data is age-adjusted and categories are defined by natural breaks using ArcGIS 10.3.1. The map was created by the South Dakota Department of Health. 7/5/2016

SD Diabetes Rate: 7.9%

(Native Americans 16%)

40,000 South Dakotan's have Prediabetes

SOUTH DAKOTA DEPARTMENT OF HEALTH

Burden of Diabetes

- Increase risk of other health complications: cardiovascular disease, nerve damage, kidney damage, eye damage, skin conditions, depression, etc.
- Diabetes management and medication adherence
- $832.1 Million spent on people with Diabetes in SD
  - Approx. $13,945 per person in SD
- Medical Expenses are **2.3X higher** for people with diabetes
- DSMES has is cost effective

Benefits of DSMES (Diabetes Self-Management Education Support)

Use primary care/prevention services

Take medications as prescribed

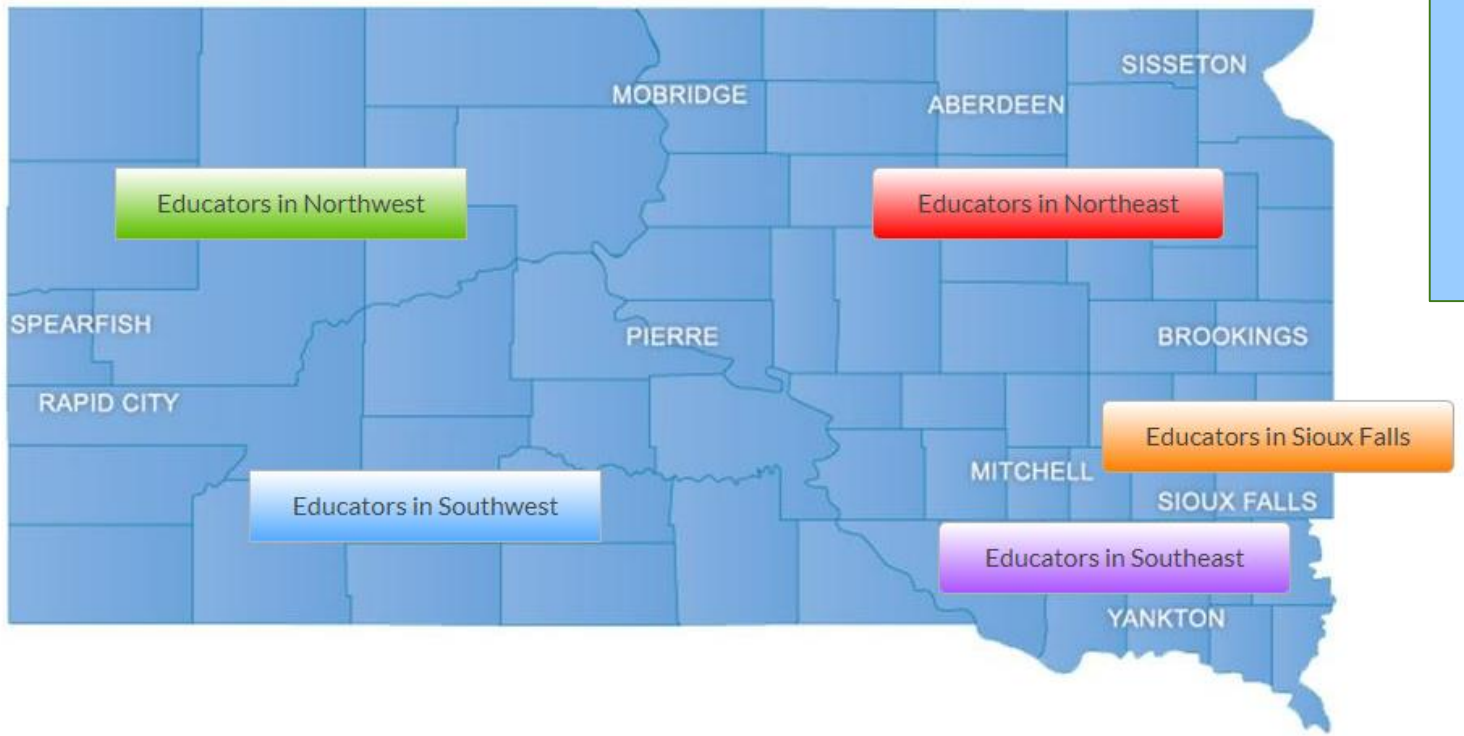
Control glucose, blood pressure, LDL Cholesterol

Have lower health costs

Meet pay for performance & QI goals

Diabetes Self-Management Education

Educators by Region



Diabetes Changes & Challenges Conference

June 27th & 28th

www.sddiabetescoalition.org

Kayla.magee@state.sd.us

FIVE Steps to Prevent Diabetes

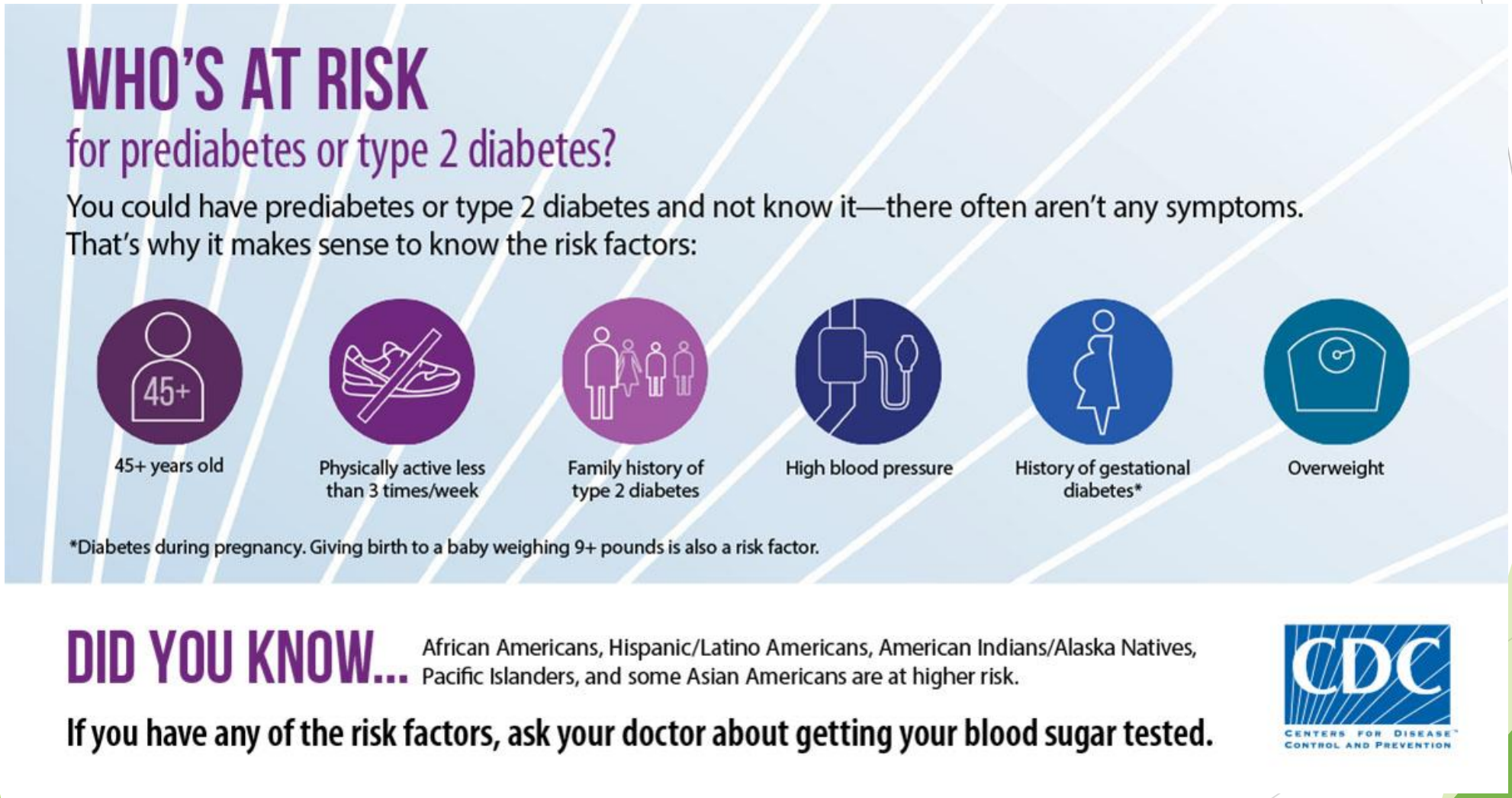
1. Create Awareness
2. Identify Patients with Prediabetes
3. Engage At-Risk Patients
4. Refer to Lifestyle Change Programs
5. Follow-up on Weight Loss progress

1. Create awareness

- Hang educational posters and distribute informational handouts
- Raise awareness among colleagues about the evidence-based diabetes prevention program and why it makes sense to screen and refer

DoIhavePrediabetes.org

2. Identify patients with prediabetes



DIAGNOSING PREDIABETES

NORMAL

HbA1C	<5.7	%
FASTING PLASMA GLUCOSE	<100	mg/dL
ORAL GLUCOSE TOLERANCE	<140	mg/dL

PATIENT INTERVENTION

- Encourage patient to maintain a healthy lifestyle.
- Retest within three years of last negative test.

PREDIABETES

HbA1C	5.7 – 6.4	%
FASTING PLASMA GLUCOSE	100-125	mg/dL
ORAL GLUCOSE TOLERANCE	140-199	mg/dL

PATIENT INTERVENTION

- Refer patient to nearest resources for diabetes prevention, such as the National Diabetes Prevention program (NDPP), Registered Dietitian, and/or fitness center.
- Encourage healthy eating and exercise.
- Retest every three years, or more frequently if risk factors are present.

DIABETES

HbA1C	6.5 +	%
FASTING PLASMA GLUCOSE	126 +	mg/dL
ORAL GLUCOSE TOLERANCE	200 +	mg/dL

PATIENT INTERVENTION

- Refer patient to a local Diabetes Self-Management Education/ Training Program (DSME/T) when: newly diagnosed, uncontrolled/poorly controlled diabetes, change in treatment regimen such as new device, recent hospital related admission.
- NOTE: Many health plans, including Medicare and Medicaid cover an annual DSME/T visit. Check with the specific health plan for more information.

ARE YOU AT RISK FOR TYPE 2 DIABETES?

DIABETES RISK TEST

Write your score in the box.

1. **ARE YOU A WOMAN WHO HAS HAD A BABY WEIGHING MORE THAN 9LBS. AT BIRTH?**
   Yes (1 POINT) No (0 POINTS)
2. **DO YOU HAVE A SISTER OR BROTHER WITH DIABETES?**
   Yes (1 POINT) No (0 POINTS)
3. **DO YOU HAVE A PARENT WITH DIABETES?**
   Yes (1 POINT) No (0 POINTS)
4. **FIND YOUR HEIGHT ON CHART (SEE ON BACK) DO YOU WEIGH AS MUCH AS OR MORE THAN THE WEIGHT LISTED FOR YOUR HEIGHT?**
   Yes (5 POINTS) No (0 POINTS)
5. **ARE YOU YOUNGER THAN 65 AND GET LITTLE OR NO EXERCISE IN A TYPICAL DAY?**
   Yes (5 POINT) No (0 POINTS)
6. **ARE YOU BETWEEN THE AGES OF 45 AND 64?**
   Yes (5 POINTS) No (0 POINTS)
7. **ARE YOU 65 YEARS OF AGE OR OLDER?**
   Yes (9 POINTS) No (0 POINTS)

TOTAL SCORE

M.A.P. (Measure, Act, Partner)

THE M.A.P. (Measure, Act, Partner) to prevent type 2 diabetes—physicians and care teams can use this document to determine roles and responsibilities for identifying adult patients with prediabetes and referring to community-based diabetes prevention programs. "Point-of-Care" and "Retrospective" methods may be used together or alone.

Choose and check what works best for your practice

Step 1: Measure	When	Who	How (draw from AMA-CDC tools)
Point-of-care method o Assess risk for prediabetes during routine office visit o Test and evaluate blood glucose level based on risk status	o At the front desk o During vital signs	o Receptionist o Medical assistant o Nurse o Physician o Other _____	o Provide "Are you at risk for prediabetes?" patient education handout in waiting area o Use/adapt "Patient flow process" tool o Use CDC or ADA risk assessment questionnaire at check-in o Display 8 x 11" patient-facing poster promoting prediabetes awareness to your patients o Use/adapt "Point-of-care algorithm"
Retrospective method o Query EHR to identify patients with BMI ≥24* and blood glucose level in the prediabetes range	o Every 6–12 months	o Health IT staff o Other _____	o Use/adapt "Retrospective algorithm"
Step 2: Act			
Point-of-care method o Counsel patient re: prediabetes and treatment options during office visit o Refer patient to diabetes prevention program o Share patient contact info with program provider**	o During the visit	o Medical assistant o Nurse o Physician o Other_____	o Advise patient using "So you have prediabetes … now what?" handout o Use/adapt "Health care practitioner referral form" o Refer to "Commonly used CPT and ICD codes"
Retrospective method o Inform patient of prediabetes status via mail, email or phone call o Make patient aware of referral and info sharing with program provider o Refer patient to diabetes prevention program o Share patient contact info with program provider**	o Contact patient soon after EHR query	o Health IT staff o Medical assistant (for phone calls) o Other_____	o Use/adapt "Patient letter/phone call" template o Use/adapt "Health care practitioner referral form" for making individual referrals o Use/adapt "Business Associate Agreement" template on AMA's website if needed
Step 3: Partner			
With diabetes prevention programs o Engage and communicate with your local diabetes prevention program o Establish process to receive feedback from program about your patients' participation	o Establish contact before making 1st referral	o Medical assistant o Nurse o Physician o Other_____	Use/adapt "Business Associate Agreement" template on AMA's website if needed Refer to "Commonly used CPT and ICD codes"
With patients o Explore motivating factors important to the patient o At follow-up visit, order/review blood tests to determine impact of program and reinforce continued program participation o Discuss program feedback with patient and integrate into care plan	o During office visit o Other_____	o Office manager o Other_____	o Advise patient using "So you have prediabetes … now what?" handout and provide CDC physical activity fact sheet **www.cdc.gov/physicalactivity**

*These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

Following the M.A.P. for Preventing Type 2 Diabetes can help your practice achieve Patient Centered Medical Home (PCMH) recognition, as well as Meaningful Use of your electronic medical record. (Supports PCMH recognition via Standard 4: Self-Care Support, B. Provide Referrals to Community Resources (3 points), *NCQA Facilitating PCMH Recognition, 2011.*)

** To share patient contact information with a diabetes prevention program, you may need a Business Associate Agreement (BAA).

The American Medical Association and the Centers for Disease Control and Prevention have created a tool kit that can help physician practices screen and refer patients to evidence-based diabetes prevention programs. Visit **preventdiabetesstat.org** to learn more. Physicians and other health care providers should also use their independent judgment when referring to a diabetes prevention program.

3. Engage At-Risk Patients

- Discuss their risk factors and higher risk of Type 2 Diabetes
- Use the term “Prediabetes”
- Emphasize significance of diagnosis
- Ask about patient’s questions, concerns and feelings
- Explain there is a strong chance to prevent or delay Type 2 Diabetes by losing modest amount of weight (10-15 lbs), being more active, and in some cases, taking medication.

4. Refer to Lifestyle Change Programs

Better Choices Better Health

- No Cost
- 6 weeks
- Lead by Trained Leaders
- Peer support in group setting
- Some programs for all chronic diseases, some specific to diabetes
- Problem solve, create action plans and manage multiple chronic conditions

National Diabetes Prevention Program

- Costs depend on program
- CDC Recognized & Evidence Based
- Proven to reduce risk by 50%
- Year long support
  - First 6 months weekly
  - Second 6 months 1-2X/month
- Facilitated by trained Lifestyle Coach
- Peer support in group setting

BETTER CHOICES
better health®
GOOD&HEALTHY SOUTH DAKOTA COMMUNITIES

Available Workshops:

BETTER CHOICES better health CHRONIC DISEASE

CHRONIC DISEASE WORKSHOPS have been designed to bring adults living with different physical and/or mental health conditions and caregivers together to learn new ways to problem solve, create action plans and manage multiple chronic conditions.

BETTER CHOICES better health DIABETES

DIABETES WORKSHOPS are designed for adults living with pre-diabetes, type-2 diabetes, and caregivers. Special emphasis will be placed on monitoring, identifying symptoms of hypoglycemia, preventing complications, foot care and menu planning.

BETTER CHOICES better health CHRONIC PAIN

CHRONIC PAIN WORKSHOPS are for adults living with chronic pain. Participants will learn about the differences between acute and chronic pain, how to pace activity, prioritize rest, and balance life.

BETTER CHOICES better health WORKSITES

WORKSITE CHRONIC DISEASE WORKSHOPS are supported by employers for their employees to discuss the challenges of balancing work and a chronic condition. Participants will learn new techniques to manage their health conditions, and how to balance work and home life with an emphasis on stress management.

OCTOBER 2014-DECEMBER 2018 PROGRAM REPORT

PARTICIPANTS

1319 people have attended a workshop...

... of those who attended a workshop, **66%** have attended at least **4** out of the **6** sessions

142 WORKSHOPS HELD IN THE FOLLOWING COMMUNITIES

- Evidence-based to reduce patients risk for type 2 diabetes
- Patients get full year of support
- Facilitated by a trained Lifestyle Coach
- Use of CDC-Curriculum
- Highly interactive and outcomes driven
- Emphasis on behavior modification through sensible sustainable changes along with managing stress and peer support

https://www.cdc.gov/diabetes/prevention/index.html

5. Follow up on Weight loss

“Problems worthy of attack prove their worth by fighting back.” – Piet Hein

Kayla's Treasure Chest of Resources

- Order DOH Materials: www.doh.sd.gov/catalog
- Pre-Diabetes Screening Model Policy:

http://goodandhealthysd.org/healthcare/practice-guidelines/

- AMA/CDC Provider's Toolkit: www.preventdiabetesstat.org
- CDC's National Diabetes Prevention Program homepage: https://www.cdc.gov/diabetes/prevention/index.html
- National DPP Customer Service Center: https://nationaldppcsc.cdc.gov/s/
- CDC and Prevention Diabetes Prevention Recognition Program Standards and Operating Procedures: https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf
- American Diabetes Association: http://www.diabetes.org/
- American Association of Diabetes Educators: https://www.diabeteseducator.org/

Treasure Chest of Resources (Cont.)

- Organizational Capacity Assessment for Applicant Organizations to the CDCs DPRP https://www.cdc.gov/diabetes/prevention/pdf/capacity-assessment.pdf
- National Diabetes Prevention Program Coverage Toolkit https://coveragetoolkit.org/
- National DPP Infographic https://www.cdc.gov/diabetes/library/socialmedia/infographics.html#tabs-2-3
- "So…Do I have Prediabetes" website for patients https://doihaveprediabetes.org/
- "So…Do I have Prediabetes" Awareness Campaign Toolkit http://prediabetes.adcouncilkit.org/
- South Dakota Diabetes Coalition's "What is Prediabetes" website pages: http://www.sddiabetescoalition.org/prediabetes-awareness.html
- American College of Preventative Medicine DPP Resource Center: https://www.acpm.org/page/dppresources